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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1906 CERTIFICATE OF DEATH

01899

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ST. MARY'S</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place) <u>4 WEEK'S</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MECHANICSVILLE 18X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) _____			
3. NAME OF DECEASED (Type or Print) <u>RONALD CRAIG BURROUGHS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 18 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE-US</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JANUARY 21, 1960</u>	9. AGE last birthday yrs. <u>—</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>LUTHER KENNETH BURROUGHS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA P. LONG.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>L. KENNETH BURROUGHS</u> <u>MECHANICSVILLE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1774X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>4 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PREMATURITY (6 1/2 mos Gestation)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>60</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>60</u> , and that death occurred at <u>1:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville, Md.</u>			
DATE SIGNED <u>2/19/60</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/60</u>		NAME OF CEMETERY OR CREMATORY <u>All Faith Cemetery</u>		LOCATION (City, town, or county) (State) <u>Charlotte Hall, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 24 60</u>		REGISTRAR'S SIGNATURE <u>W. Clarke Mattingley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonardtwn, Maryland</u>			
DATE <u>2266 295XVI</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tompkinsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians' Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jr. Last Chisley				4. DATE OF DEATH Month 2 Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY on Farm		11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Chisley				14. MOTHER'S MAIDEN NAME Mary Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-7672		17. INFORMANT Mr. William Chisley - Brother-Tompkinsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Gangrene Lower Extremities 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Compression of Spinal Cord DUE TO (c) Falling from moving truck						INTERVAL BETWEEN ONSET AND DEATH 10-15-'59 8-27-'59 8-27-'59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from moving truck					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-27 '59 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Tompkinsville, Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. Edelen, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/1960		22c. NAME OF CEMETERY OR CREMATORY Archart Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Funeral Home, Inc.</i>				24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Physicans Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1123 - 11th. Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR WILLIAM FOSTER		4. DATE OF DEATH Month FEBRUARY Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK MAN		10b. KIND OF BUSINESS OR INDUSTRY MURPHY (STORE)	
11. BIRTHPLACE (State or foreign country) LURAY, VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd Foster		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown) RAMEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 577-28-4183	
17. INFORMANT Mrs. Mildred Foster - 1123 - 11th. St. N.W., DC.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 812X DUE TO SKULL FRACTURE (RIGHT PTERIOUS BONE) and COMPOUND FRACTURE LEFT TIBIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> PEDESTRIAN - Struck by auto - 1 1/2 mi. No. WALDORF		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway Waldorf, Charles, Md.	
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 2-20 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Waldorf, Charles, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE J.B. Detton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V.B. DETTON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/25/60	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - WASH. D.C.		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1909 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) L2 Plata		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Waldorf	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle I Last Gardiner		4. DATE OF DEATH Month Feb. Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Middleton		14. MOTHER'S MAIDEN NAME Isabelle Bowling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hugh C. Gardiner Jr, Fawltner, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 12, 1960 , to 2-25, 1960 , that I last saw the deceased alive on 2-25, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) L2 Plata, Md. DATE SIGNED 2-26-60 ACTUAL SIGNATURE E. J. Edelen M.D. L. A. Plata PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-60	22c. NAME OF CEMETERY OR CREMATORY St Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 2-9-60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>		<p>4. RACE [Handwritten: White]</p>		<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>	
<p>6. DATE OF DEATH [Handwritten: Jan 15, 1945]</p>		<p>7. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>8. PLACE OF DEATH [Handwritten: Home]</p>		<p>9. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>10. MANNER OF DEATH [Handwritten: Natural]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Handwritten: J. Smith]</p>		<p>12. SIGNATURE OF REGISTRAR [Handwritten: A. Jones]</p>		<p>13. SIGNATURE OF WITNESS [Handwritten: B. Brown]</p>		<p>14. SIGNATURE OF WITNESS [Handwritten: C. Green]</p>		<p>15. SIGNATURE OF WITNESS [Handwritten: D. White]</p>	
<p>16. SIGNATURE OF WITNESS [Handwritten: E. Black]</p>		<p>17. SIGNATURE OF WITNESS [Handwritten: F. Gray]</p>		<p>18. SIGNATURE OF WITNESS [Handwritten: G. Blue]</p>		<p>19. SIGNATURE OF WITNESS [Handwritten: H. Red]</p>		<p>20. SIGNATURE OF WITNESS [Handwritten: I. Yellow]</p>	

1845 1846 1847 1848 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860 1861 1862 1863 1864 1865 1866 1867 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000

1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. RACE
 5. PLACE OF BIRTH
 6. DATE OF DEATH
 7. TIME OF DEATH
 8. PLACE OF DEATH
 9. CAUSE OF DEATH
 10. MANNER OF DEATH
 11. SIGNATURE OF PHYSICIAN
 12. SIGNATURE OF REGISTRAR
 13. SIGNATURE OF WITNESS
 14. SIGNATURE OF WITNESS
 15. SIGNATURE OF WITNESS
 16. SIGNATURE OF WITNESS
 17. SIGNATURE OF WITNESS
 18. SIGNATURE OF WITNESS
 19. SIGNATURE OF WITNESS
 20. SIGNATURE OF WITNESS

1910 CERTIFICATE OF DEATH

01903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First James Middle Enoch Last Garner		4. DATE OF DEATH Month Feb Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Garner		14. MOTHER'S MAIDEN NAME Zora Rawlins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Fred Garner, Brandywine, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 442X DUE TO Chronic C.V. R. Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) at least 1 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unability to swallow due to esophageal cancer			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 , 19 60 , to 2/11 , 19 60 , that I last saw the deceased alive on 2/10 , 19 60 , and that death occurred at 10:15 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V. M. Seaton MD		ADDRESS (Street, city or town, state) Waldorf Md DATE SIGNED 2/12/60	
PHYSICIAN'S NAME (Type) V. M. SEATON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-60	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Waldorf, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01904


1911 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GARNER</u> Last <u>GARNER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNK, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK, Garner</u>		14. MOTHER'S MAIDEN NAME <u>Sally Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Alice Wade, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Acute Bacterial Broncho Pneumonia</u> <u>471X</u> DUE TO (b) <u>Acute Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Valvular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>60</u> , to <u>Feb 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>60</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V.M. Seron</u> M.D.		DATE SIGNED <u>2/13/60</u>	
PHYSICIAN'S NAME (Type) <u>V.M. SERON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>	22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Pious</u>	

123

WILLIAM E. BRNER



1912 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b Rock Point, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Eunice Marie GOOSEBERRY				4. DATE OF DEATH FEB. 6 1960			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1956		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Gooseberry				14. MOTHER'S MAIDEN NAME Helena Smathers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Joseph R. Gooseberry, Rock Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X Bilateral Bronchopneumonia IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30 , 19 60 , to 2-6 , 19 60 , that I last saw the deceased alive on 2-6 , 19 60 , and that death occurred at 9:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED La Plata, Md. 2-6-60							
ACTUAL SIGNATURE F. M. Johnson				M.D. La Plata, Md.			
PHYSICIAN'S NAME (Type) F. M. JOHNSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1960		22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		22d. LOCATION (City, town, or county) (State) Issue, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart, Inc. ADDRESS Archart Funeral Home, Inc. LaPlata, Md.				24a. REC'D BY REGISTRAR DATE FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1113 CERTIFICATE OF DEATH



1913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Physicians Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle FRANCIS Last GREENE				4. DATE OF DEATH Month 2 Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 16, 1906	
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal worker				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward F. Greene				14. MOTHER'S MAIDEN NAME Mary E. Fowkes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-03-1531			
17. INFORMANT Mrs. Mary E. Michael-Sister, Cobb Island Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, Pulmonary 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4-59-2-60 DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1960 , to 2-24 , 19 60 , that I last saw the deceased alive on 2-24 , 19 60 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 2-24-60 ACTUAL SIGNATURE E. J. Edelen M.D. PHYSICIAN'S NAME (Type) E. J. Edelen, M.D. La Plata, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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CERTIFICATE OF DEATH

1913

Reg. Dist. No.

1. PLACE OF DEATH (County)		2. DATE OF DEATH	
3. TIME OF DEATH		4. PLACE OF BIRTH	
5. SEX		6. AGE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. MEDICAL HISTORY	
11. PRESENT ILLNESS		12. PREVIOUS ILLNESSES	
13. PRESENT ILLNESS		14. PREVIOUS ILLNESSES	
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REGISTRATION NO.

1. NAME OF DECEASED
2. DATE OF DEATH
3. PLACE OF DEATH
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5. AGE
6. OCCUPATION
7. CAUSE OF DEATH
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96. PREVIOUS ILLNESSES
97. PRESENT ILLNESS
98. PREVIOUS ILLNESSES
99. PRESENT ILLNESS
100. PREVIOUS ILLNESSES

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01907

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN life Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Waldorf		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD LEWIS HOWE				4. DATE OF DEATH Month Day Year February 10 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1959		9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Lawrence Howe				14. MOTHER'S MAIDEN NAME Ethel Marie Lergen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Matthew Lawrence Howe, Waldorf, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i> EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		DATE SIGNED 2/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-12-60	22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or country) (State) Bryantown, Maryland			
23. FUNERAL DIRECTOR ADDRESS The Hunt Funeral Home, Waldorf, Maryland				24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

2066204XV4

THE STATE
OF NEW YORK

1913

IN SENATE,
January 1, 1913.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1912.

ALBANY:
J.B. LIPPINCOTT & CO., PRINTERS,
1913.

THE LAND OFFICE
OF THE STATE OF NEW YORK
ALBANY, N. Y.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
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1913.

THE LAND OFFICE
OF THE STATE OF NEW YORK
ALBANY, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G257 2-29-60 et

1915

CERTIFICATE OF DEATH

Reg. Dist. No.

01908

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leon Middle W. Last James				4. DATE OF DEATH Month Feb. Day 20 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Rochester, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Fredrick James				14. MOTHER'S MAIDEN NAME Kate Eustace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 01-123456789		17. INFORMANT David James Port Tobacco Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) Cancer Larynx with Surgery							INTERVAL BETWEEN ONSET AND DEATH 2-20-'60 1950 Jan. 1960
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 1953 , to 2-20 , 19 60 , that I last saw the deceased alive on Dec. 30 , 19 60 , and that death occurred at 2 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. J. Edelen M.D. 2-22-'60							
ACTUAL SIGNATURE E. J. Edelen							
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/60		22c. NAME OF CEMETERY OR CREMATORY Lee's		22d. LOCATION (City, town, or county) (State) Washington Dc	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Inc Laplata Md.				24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

FILE NO.

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH 1912	
NAME OF DECEASED [Name]		SEX [Male/Female]	
AGE [Age]		RACE [Race]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]	
MARITAL STATUS [Married/Single/etc.]		CAUSE OF DEATH [Cause]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]	
PLACE OF DEATH [Place]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		CERTIFICATE NO. [Number]	

SEE LAST PAGE

1

IN THE CITY OF BALTIMORE, MD, I, the undersigned, Registrar of the Department of Health, do hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in my office on the [Date] day of [Month], 1912.

ATTEST:
 [Signature]
 REGISTRAR

Item 1 Film G257 2-26-60 et
1916 CERTIFICATE OF DEATH

Reg. Dist. No.

01909

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lapla</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lapla</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>				1. d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>YVETTE</i> Middle <i>MARIE</i> Last <i>JENKINS</i>				4. DATE OF DEATH Month <i>FEB</i> Day <i>21</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-18-59</i>		9. AGE (In years last birthday) <i>10</i> yrs.	IF UNDER 1 YEAR Months <i>10</i> Days <i></i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Child</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas E Jenkins</i>				14. MOTHER'S MAIDEN NAME <i>Anna Beat Thomas</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>None</i>		INFORMANT <i>Thomas E Jenkins Lapla</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pneumonia</i> <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>1-18</i> , 19 <i>60</i> to <i>2-21</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2-21</i> , 19 <i>60</i> , and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F. M. Johnson</i>				ADDRESS (Street, city or town, state) <i>Lapla Md.</i> DATE SIGNED <i>2-21-60</i>			
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/21/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Scopus Heart</i>		22d. LOCATION (City, town or county) (State) <i>Lapla Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kraus</i>				24a. REC'D BY REGISTRAR <i>Feb 24 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF MICHIGAN LIBRARY

1980-1981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1917 CERTIFICATE OF DEATH

01910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lz Plata		c. LENGTH OF STAY IN 1b Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle Magdoline Last JOHNSON		4. DATE OF DEATH Month FEB Day 16 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Wise		14. MOTHER'S MAIDEN NAME Cecelia Cullison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Phillip Johnson, Rock Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ATHEROSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-15 , 19 60 , to 2-16 , 19 60 , that I last saw the deceased alive on 2-15 , 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lz Plata, Md. DATE SIGNED 2-16-60			
ACTUAL SIGNATURE J. M. Johnson M.D.		PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-60	22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cem.	22d. LOCATION (City, town, or county) (State) Issue, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The HUNTT Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE FEB 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Madeline

CERTIFICATE OF DEATH

01911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francis Middle Philip Last Moran				4. DATE OF DEATH Month Feb Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1888	
9. AGE (In years last birthday) 72 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Moran				14. MOTHER'S M maiden NAME Alice Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Marianna Canter, Hughesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coron. Ht. Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Bronchial Asthma INTERVAL BETWEEN ONSET AND DEATH 2-10-60 1950							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 to 2-11 , 19 60 , that I last saw the deceased alive on 2-11 , 19 60 , and that death occurred at 11 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 2-12-60							
ACTUAL SIGNATURE E. J. Edelen M.D.							
PHYSICIAN'S NAME (Type) E. J. Edelen, MD				La Plata, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-60		22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		22d. LOCATION (City, town, or county) (State) Bryantown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE FEB 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01912

1918

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Waldorf				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Richard Moreland				4. DATE OF DEATH Month FEBRUARY Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 5, 1958	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Louis Moreland				14. MOTHER'S MAIDEN NAME Helen Irene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Irene Moreland, Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Skull Fracture DUE TO (b) 823x Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 1 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - Rt. 382			
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 2-8-60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway				20f. (City or town) (County) (State) Waldorf, Charles, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE V.B. Detton				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) V.B. DETTOR				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-60		22c. NAME OF CEMETERY OR CREMATORY St Peters		22d. LOCATION (City, town, or county) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland				ADDRESS The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR Feb 12 60	
				24b. REGISTRAR'S SIGNATURE Wm. S. Thoms		DATE 2/8/60	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

John. Richard

1920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomfret		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomfret	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) CAROLINE V. PROCTOR		4. DATE OF DEATH Month Feb Day 5 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1876
9. AGE (In years less birthday) yrs. 83		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustine Butler		14. MOTHER'S MAIDEN NAME Elizabeth Ann Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Lee Proctor, Pomfret, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15, 1959 , to 2-4, 1960 , that I last saw the deceased alive on 1-20-60 , 19____, and that death occurred at 6 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. M. JOHNSON		ADDRESS (Street, city or town, state) DATE SIGNED The Plaza, Md. 2-6-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-9-60	22c. NAME OF CEMETERY OR CREMATORY St Josephs	22d. LOCATION (City, town, or county) (State) Pomfret, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01914

1921

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>		c. LENGTH OF STAY IN 1b <u>29 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Marbury</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Spencer</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-78</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church of God</u>	
11. BIRTHPLACE (State or foreign country) <u>Yazoo County, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jefferson Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Caldwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-16 1995</u>	
17. INFORMANT Address <u>Mrs John S. Reynolds Marbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>2/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>60</u> , and that death occurred at <u>12:20</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Puscher</u> M.D.		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>2/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>Feb 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>			

CERTIFICATE OF DEATH

1901

PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH JANUARY 1, 1890	
NAME OF DECEASED JOHN A. BROWN		SEX MALE	
OCCUPATION LABORER		COLOR WHITE	
PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH JANUARY 15, 1901	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH CONSUMPTION	
MEDICAL ATTENDANT DR. J. H. BROWN		PLACE OF INTERMENT GREENWICH CEMETERY	
SIGNATURE OF MEDICAL ATTENDANT J. H. BROWN		SIGNATURE OF REGISTRAR J. H. BROWN	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as stated above.		REGISTERED JANUARY 16, 1901	

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 JANUARY 16, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1922

CERTIFICATE OF DEATH

Reg. Dist. No.

01915

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CATHERINE First BLANCHE Middle ROBEY Last				4. DATE OF DEATH FEB Month 1 Day 19 Year 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Sinclair				14. MOTHER'S MAIDEN NAME Jane Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Samuel Robey Waldorf (Husband) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Disease DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH Sudden years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 26, 1960 , to Feb 1, 1960 , that I last saw the deceased alive on Jan 30, 1960 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Valeh M. Sekon				DATE SIGNED 2/1/60			
PHYSICIAN'S NAME (Type) VALEH M SEKON MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb. 3, 1960		St. Joseph's		Pomfret, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Heath Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Wm. S. Tuma	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

18&21 Film 258-10-60 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Items 7, 11, 12, 13, 14 Film G257-2-29-60 et											
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grayton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Grayton						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grayton d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First IDA Middle SANDERS Last SANDERS			4. DATE OF DEATH Month February Day 15 Year 1960			5. SEX Female			6. COLOR OR RACE Colored		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 57			9. AGE (In years less birthday) 57			IF UNDER 1 YEAR Months 57 Days 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Grayton, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Guthrie						14. MOTHER'S MAIDEN NAME Annie Shivers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheobronchitis 501X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher M.D.						CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 2/17/60		
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2-20-60			22c. NAME OF CEMETERY OR CREMATORY Grayton			22d. LOCATION (City, town, or country) (State) Grayton Md		
23. FUNERAL DIRECTOR W N Bacon ADDRESS 1722 74 St. NW						24a. REC'D BY REGISTRAR FEB 23 '60			24b. REGISTRAR'S SIGNATURE C. H. S. Fisher		

VS. A15ME
5M 7/59

1955

05/19/55

W. H. Brown 11-2-55 12/1/55
R. H. Brown 11-2-55 12/1/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grayton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Grayton						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grayton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPHINE			First Middle Last SANDERS			4. DATE OF DEATH Month February Day 15 Year 19 60					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Grayton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley						14. MOTHER'S MAIDEN NAME Sarah Montgomery					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Sarah Montgomery				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/17/60											
ACTUAL SIGNATURE Russell S. Fisher, M.D.		EXAMINER'S NAME (Type) Russell S. Fisher, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-60		22c. NAME OF CEMETERY OR CREMATORY Church		22d. LOCATION (City, town, or country) Grayton, Md.		(State)			
23. FUNERAL DIRECTOR W. H. Bacon						ADDRESS 1722 1/2 St. N.W.		24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harts	

1001

RECEIVED

Charles

1001

Charles

Charles

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1001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
Items 7, 11, 12, 13, 14 Film 6257 2-29-60 et															
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)													
a. COUNTY		Charles				a. STATE		Maryland				b. COUNTY		Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Grayton				d. STREET ADDRESS						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
ROBERT						SANDERS		February		15		19		60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				65 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
				Grayton, Maryland		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
John Wesley		Sarah Montgomery													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
422.1 DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
19															
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		R. S. Fisher		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/17/60			
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.				Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)							
Burial		2-20-60		Grayton		Grayton, Md									
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
W. H. Bacon		1722 7th Ave		FEB 23 '60		Arthur S. Kraus									

MAINTENANCE OF RECORDS
IN THE OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
1952

REPORT OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
ON THE
MAINTENANCE OF RECORDS
IN THE OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
1952

MAINTENANCE OF RECORDS
IN THE OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
1952

MAINTENANCE OF RECORDS
IN THE OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G256 2-23-60 et

1926

CERTIFICATE OF DEATH

Reg. Dist. No.

01919

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Mem. Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>DELLA</i> Middle <i>SAVOY</i> Last <i>SAVOY</i>				4. DATE OF DEATH Month <i>FEB</i> Day <i>12</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1876</i>		9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months <i>83</i> Days <i>83</i> Hours <i>83</i> Min. <i>83</i>	IF UNDER 24 HRS. Months <i>83</i> Days <i>83</i> Hours <i>83</i> Min. <i>83</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Brown</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Johnson</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>Informant</i>		Address <i>La Plata, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>455X</i> DUE TO <i>Sanseone of left foot</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO <i>3 weeks</i> (c) DUE TO <i>3 weeks</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> , to <i>2-12</i> , 1960 that I last saw the deceased alive on <i>2-12</i> , 1960, and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.				ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>2-12-60</i>			
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 15 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Catharine Cem</i>		22d. LOCATION (City, town, or county) (State) <i>La Plata, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anthony Funeral Home</i> ADDRESS <i>Waldorf Md</i>				24a. REC'D BY REGISTRAR <i>FEB 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD FORM NO. 64

Wm. L. Brown

100, 5002 and 1002

Thos. Brown

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

1934 - CERTIFICATE OF DEATH

COUNTY OF MARYLAND CITY OF BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED JAMES EARL RAY		SEX Male	
DATE OF BIRTH 12-1-27		PLACE OF BIRTH Memphis, Tenn.	
DATE OF DEATH 4-4-68		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:15 AM		CAUSE OF DEATH 1. Myocardial Infarction 2. Atherosclerosis of the coronary arteries	
MEDICAL HISTORY No previous illness noted.		OCCUPATION Actor	
MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF BURIAL OFFICIAL [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

1928 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bryantown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David A. Tolson</u>		4. DATE OF DEATH Month Day Year <u>Feb. 14 1960</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26 1959</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Coats</u>		14. MOTHER'S MAIDEN NAME <u>Frances Tolson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address <u>Frances Tolson, Waldorf, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Viral Pneumonia</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>2d</u> <u>5d</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>60</u> , to <u>2-14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>60</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D. <u>Bryantown</u> PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M.D. - Bryantown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Huntt Funeral Home</u> <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1929 CERTIFICATE OF DEATH

Reg. Dist. No.

01922

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Thomas Middle Joseph Last Wright				4. DATE OF DEATH Month Feb Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Wright				14. MOTHER'S MAIDEN NAME Sallie Barker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Sp. Amer. War		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Theodore DeLozier, Marbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis 420.1 DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c)						INTERVAL BETWEEN DEATH 2 yrs DEATH yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13th, 1956 , to February 21, 1960 that I last saw the deceased alive on Feb. 2nd., 1960 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paul Chen		M.D. Accokeek, Md. 2-3-60					
PHYSICIAN'S NAME (Type) Paul Chen, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland				24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing it "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomfret Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Pomfret, rural</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Kevin First JUAN Middle YATES Last</i>		4. DATE OF DEATH Month <i>2</i> Day <i>16</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-5-29</i>
9. AGE (in years last birthday) yrs. <i>2</i> Months <i>11</i> Days <i>11</i> Hours <i>Min.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>J. THOMAS YATES</i>		14. MOTHER'S MAIDEN NAME <i>DOROTHY TAYLOR</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Dorothy Elaine Yates, Pomfret, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493x</i> DUE TO <i>Had some cold - prob</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i> (c) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2-16-60</i> <i>2-15-60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>2-17-60</i>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-18-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) (State) <i>Pomfret Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 18 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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